STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	OMB NO. 0938-0
AND FLAM	OF CORRECTION	IDENTIFICATION NUMBER:		ING	(X3) DATE SURVE COMPLETED
NAME OF	DROWNER OF CHICAL	09G254	B WING		02/08/2019
	PROVIDER OR SUPPLIE	3		STREET ADDRESS, CITY, STATE, Z	P CODE
DC HEA	LTH CARE, INC		1	WASHINGTON, DC 20011	
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION
TAG	REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE COMPLE HE APPROPRIATE DATE
W 000	INITIAL COMMEN	TS	W 00	00	
	A recertification su	rvey was conducted from			
	02/06/19 to 02/08/	19. A sample of three clients		T U	
	two remaies. The s	a population of thee males and urvey was conducted utilizing		i	
	the focused fundar	nental survey process.			
	The findings of the	survey were based on			
-	observations, inter-	IBWS and review of client and			3
- 4	administrative reco	rds.		V	
1	The following abbre throughout the repo	viations will appear rt:			
	ASAP - As Soon As	Donaible			
í	IPP - Individual Prod	ram Plan			ă.
	LPN - Licensed Pra-	ctical Nurse			
N 249 F	RN - Registered Nu PROGRAM IMPLEN	AENTATION			
(CFR(s): 483.440(d)(1)	W 249		
1 P	As soon as the inter	disciplinary team has			6
10	ormulated a client's	individual program plan		Î	
tr	eatment program c	eive a continuous active onsisting of needed		į.	
ır	iterventions and ser	vices in sufficient number		*	
а	nd frequency to sup	port the achievement of the			1
p	an.	n the individual program			v v
					å
1		1			Î
TI	his STANDARD is	not met as evidenced by:			į.
re	view, the facility fail	n, interview and record ed to ensure that each	i		#
CII	ent's self-medicatio	n training program was			
ım	pjemented when th	e opportunity was			
pr	esented, for one of	three clients in the sample	1		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that following the date of survey whether or not a plan of correction is provided. For nursing homes, the findings stated above are disclosable 90 days days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES	CARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(Mei talli	0	FORM APPROVE MB NO. 0938-039
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G254	B. WING		****
NAME OF PROVIDER OR SUPP	LIER		STREET ADDRESS, CITY, STATE, ZIP CODE	02/08/2019
DC HEALTH CARE, INC			WASHINGTON, DC 20011	
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMBINED
W 249 Continued From	m page 1	144.04	1	1
(Client #2).	n page 1	W 24	9	3
Findings include	ed:	2		·
punched one m and handed the Client #2 then c	5:07 PM, observations of the tion pass showed that the LPN edication into a medication cup medication cup to Cllent #2. onsumed the medication, picked		The medication nurses were retrain by the RN on 02/11/19. The RN ar QIDP will monitor the self-medication program for all people daily for two weeks and monthly for three months.	nd on
up his water and	d drank the water.	į	(Please see Attachment "A1, A2")	I
self-medication "You have to ask	LPN said during an interview that a any of the clients' had a program. The LPN then stated, the RN". It should be noted that are facility at the time the occurred.			
supervision by lic participate in his	:22 PM, review of Client #2's th 50% verbal reminders and tensed staff, [client name] will self-medication. Further review			j.
6	ed the following strategies:	3		
Pick up the me Obtain the key	dicine. to the medication box.			÷ v
3. Identify the AM	or PM card as needed.			i
5. Take the medic 6. Drink the water 7. Lock the medic	ation.	1		5
8. Secure the key. 9. Secure the med 10. Put the cup in	dication box	i		
On 02/08/19 at 12	32 PM, a telephone interview the facility's RN. The RN	i		n. û
said that Client #2	had a self-medication program	-		1

TATEMEN'	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		09G254	B. WING		00/00/00
	PROVIDER OR SUPPLIER TH CARE, INC	R		REET ADDRESS, CITY, STATE, ZIP CODE	02/08/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDER (CROSS-REFERENCE)	D. RE COURT ST
	not see the evening self-medication on stated that she wou	lemented during the AM and ss. The RN stated that she did g LPN implement Client #2's 02/06/19. The RN further all d provide in-service training molementation of Client #2's	W 249		ř.
P	At the time of the si	urvey, the facility failed to	. (*)		
а	nplement Client #2 dministration prog	2's self-medication ram, as recommended.	1		7
ä	npiement Client #2 dministration progi	2's self-medication			***
a	npiement Client #2 dministration progi	2's self-medication			7 8
a	npiement Client #2	2's self-medication			7 3 3 20 4
a	nplement Client #2	2's self-medication			
i a	mplement Client #2	2's self-medication			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY
		A. BUILDING:		COMPLETED
	HFD03-0286	B. WING		02/08/2019
NAME OF PROVIDER OR SUPPLIER	STREET	DORESS, CITY, 9	TATE, ZIP CODE	92.00,2010
DC HEALTH CARE, INC	WASHIN	GTON, DC 20	011	
(X4) ID SUMMARY ST. PREFIX (EACH DEFICIENCE	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF	CORRECTION
TAG REGULATORY OR L	SCIDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE COMPLET THE APPROPRIATE DATE
1000 INITIAL COMMEN	rs	1000		A STATE OF THE STA
A licensure survey	was conducted from 02/06/19			
, was selected from a	sample of three residents a population of three males			
and two females wi	th varving degrees of			
intellectual disabilitie	es.			1
The findings of the	survey were based on			
and administrative r	lews, and reviews of resident	1 1		
1				I
Note: The below are appear throughout the	e abbreviations that may ne body of this report.			
ASAP - As Soon As	Possible			
GHIID - Group Home Intellectual Disabilitie	e for Individuals with			
IPP - Individual Prog	ram Plan			V.
QIDP - Qualified Inte	llectual Disabilities			
RN - Registered Nurs	se			
1 422: 3521.3 HABILITATIO	N AND TRAINING	1422		ì
Each GHMRP shall p	rovide habilitation, training			1
and assistance to res the resident 's Individ	idents in accordance with			
This Statute is not me	et as evidenced by:			
Based on observation	, interview and record			
review, the GHIID faile resident's self-medica	ed to ensure that each tion training program was			
implemented when the	e opportunity was			
presented, for one of the sample (Resident #2).	hree residents in the			
1				
Findings included:				
On 02/06/19 at 5:07 Pi evening medication pa egulation & picensing Administrat	ss showed that the I PN			į
ORY DIRECTOR'S OR PROVIDER	ION SUPPLIER REPRESENTATIVE'S SIGNA	TURE	O TITLE	(VA) GAT-
100			D	(X6) DATE 1967 3/8/1
ORM	600	YEYK	11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	If continuation sheet that

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Health Regulation & Li				FOR	MAPPROVE
STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	S (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION 3:	(X3) DAT	TE SURVEY MPLETED
	HFD03-0286	B. WING		02	/08/2019
IAME OF PROVIDER OR SUP	PLIER STREET	ADDRESS, CITY.	STATE, ZIP CODE	02	100/2013
OC HEALTH CARE, INC					
PREFIX (EACH DEFI	WASHIF RY STATEMENT OF DEFICIENCIES EILENCY MUST BE PRECEDED BY FULL 'OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X6) COMPLETE DATE
1422 Continued Fro	m page 1	1 422			-
punched one rand handed the Resident #2 the picked up his was at the RN was in the RN was conducted when the RN was conducted when the RN was in the RN was conducted when the RN was in the RN was conducted when the RN was in the RN was conducted when the RN was conducted when the RN was conducted when the RN was in the RN	nedication into a medication cup e medication cup to Resident #2. en consumed the medication, vater and drank the water. LPN said during an interview that k any of the residents' had a program. The LPN then stated, k the RN". It should be noted that he GHIID at the time the s accurred. 1:22 PM, review of Resident #2's vith 50% verbal reminders and h licensed staff, [resident name] h his self-medication. Further revealed the following edicine. v to the medication box. for PM card as needed. cation pills from the package into cation. cation box. for cation box.		The medication nurses we retrained by the RN on 02. The RN and QIDP will mother self-medication prograll people daily for two we monthly for three months. Please see Attachment "A	/11/19. Initor Im for Ieks and	02/11/19

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Health Regulation & Licens STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVE
	IDENTIFICATION NOWIBER.	A. BUILDING:		COMPLETED
	HFD03-0286	B. WING	4-14-	00/00/00 1
AME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE ZID CODE	02/08/2011
C HEALTH CARE, INC			JIATE, ZIP CODE	
	WASHIN	GTON, DC 20	0011	
REFIX TRACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMP
1422 Continued From pa	ige 2	1 422		
implementation of F	Resident #2's self-medication			
ASAP.				
implement Residen	urvey, the GHIID failed to the two self-medication ram, as recommended.			
				7
1				
F.				
1980				
Ÿ				
3				8
				į.
				Î
		1		
St.				

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938 (X3) DATE SURV COMPLETE		
		09G254	B. WING		00/00/00
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (02/08/20
DC HEA	ALTH CARE, INC			WASHINGTON, DC 20011	
(X4) ID PRFFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST RE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPI
E 000	Initial Comments		E 000		
	An emergency prep conducted from 02/0	aredness survey was 6/19 through 02/08/19.			
	The findings of the s	urvey were based on			
	interviews and review	v of the emergency			
	preparedness progra	ım.			
	Note: The below are appear throughout th	abbreviations that may e body of this report.			
	DSP - Direct Support	Professional			
ä	EP - Emergency Plan)			
G H	EPP - Emergency Pro HM - House Manager	eparedness Plan	,		
	PM - Program Manag	er			
	QIDP - Qualified Intel Professional	lectual Disabilities			
	EP Training Program		E 007		4
	CFR(s): 483.475(d)(1)	E 037		
	2 2 767				1
	(1) Training program.	The [facility, except CAHs, itions, PRTFs, Hospices,			1
- 2	and dialysis facilities]	must do all of the following:			
			-		
(olicies and procedure	ergency preparedness es to all new and existing			
S	staff, individuals provid	ling services under			
a	arrangement, and volu	nteers, consistent with their			
e /	expected role.	preparedness training at			
16	east annually.				
(i	ii) Maintain document	ation of the training.	N.		
i)	 v) Demonstrate staff (rocedures. 	knowledge of emergency	139		171
		.15(d) and RHCs/FQHCs			
a	1 9491-12:] (1) Trainin	g program. The [Hospital 🔠			i i
O	RHC/PQHC) must de	all of the following:			
		SUPPLIER REPRESENTATIVE'S SIGNA			9

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 program participation.

CENT	ERS FOR MEDICAL	THAND HUMAN SERVICES RE & MEDICAID SERVICES			PRINTED: 02/28/201 FORM APPROVE
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		09G254	B. WING		00/00/00 40
	PROVIDER OR SUPPLIE	R	ST	REET ADDRESS, CITY, STATE, ZIP COD	02/08/2019
DC HEA	LTH CARE, INC		l w	ASHINGTON, DC 20011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CYMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
	policies and proce staff, individuals prarrangement, and expected roles. (ii) Provide emerge least annually. (iii) Maintain docum (iv) Demonstrate si procedures. *[For Hospices at § hospice must do all (i) Initial training in expolicies and procedurospice employees, services under arrange expected roles. iii) Demonstrate statorocedures.	emergency preparedness dures to all new and existing roviding on-site services under volunteers, consistent with their ency preparedness training at mentation of the training. aff knowledge of emergency 418.113(d):] (1) Training. The of the following: emergency preparedness ures to all new and existing and individuals providing and individuals providing figurement, consistent with their eff knowledge of emergency preparedness training at	E 037		±.
e e s p	mergency prepared mployees (including pecial emphasis pla	when displayed the service of the se	-		ALTERNATION IN
(i) po st ar ex	ogram. The PRTF Initial training in en blicies and procedural aff, individuals proving rangement, and vol pected roles.	.184(d):] (1) Training must do all of the following: nergency preparedness res to all new and existing iding services under unteers, consistent with their	4		P

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIDI E	CONSTRUCTION	DMB NO. 0	-
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED 02/08/2019	
		09G254	8 WING			
NAME OF	PROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	02/08	2019
DC HEA	ALTH CARE, INC		10	SHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DRE	(X5) UMPLETION DATE
E 037	Continued From pa	ige 2	E 037			
	procedures.	aff knowledge of emergency nentation of all emergency ng.	2 007			
	(i) Initial training in a	.84(d):] (1) The PACE to all of the following: emergency preparedness				
	staff, individuals pro arrangement, contra volunteers, consiste	ures to all new and existing widing on-site services under actors, participants, and nt with their expected roles	· į		1	
	(ii) Provide emerger least annually. (iii) Demonstrate sta	ff knowledge of emergency			Ī	
	what to do, where to case of an emergen	g informing participants of go, and whom to contact in cy.	ř.			
		entation of all training.			1	
(i) Provide initial train	ing in emergency			1	
F E	oreparedness policie and existing staff, ind under arrangement, a	s and procedures to all new lividuals providing services and volunteers, consistent	3		G G	
v (i	vith their expected ro ii) Provide emergence east annually.	iles. Ly preparedness training at			1	
() P	 V) Demonstrate staff rocedures. All new p 	ntation of the training. I knowledge of emergency ersonnel must be oriented	I		į.	
th	ie CORF's emergen ieir first workday. Th	responsibilities regarding cy plan within 2 weeks of e training program must				
al	cidde instruction in t arm systems and sig quipment.	he location and use of gnals and firefighting				
			- 4		100	T

DEPAI	RTMENT OF HEALTH	AND HUMAN SERVICES				PRINT	ED: 02/28/20
CENT	ERS FOR MEDICARI	E & MEDICAID SERVICES				FC	RM APPROVE
ISTATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			NO. 0938-039 DATE SURVEY COMPLETED
		09G254	B. WING				
NAME OF	PROVIDER OR SUPPLIER		1	STR	REET ADDRESS, CITY, STATE, ZIP COD)F	02/08/2019
	LTH CARE, INC				SHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¥	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	WHITHE	(X5) COMPLETION DATE
E 037	Continued From page	ge 3	E 03	7			
	(i) Initial training in e policies and procedure reporting and extinguity.	mergency preparedness ires, including prompt uishing of fires, protection					
	and where necessar personnel, and gues cooperation with firet authorities, to all new individuals providing	y, evacuation of patients, ts, fire prevention, and fighting and disaster				¥S.	
	roles. (ii) Provide emergend east annually.	cy preparedness training at		£)			
(iii) Maintain documei iv) Demonstrate stafi procedures.	ntation of the training. f knowledge of emergency					h
p	reparedness policies nd existing staff, indi- nder arrangement, a	.920(d):] (1) Training. The nitial training in emergency and procedures to all new viduals providing services nd volunteers, consistent					7
d d pi ei	ocumentation of the lamination	es, and maintain training. The CMHC must wledge of emergency r, the CMHC must provide					i s
TI B fal kn (sp tra	nis STANDARD is no ased on interview an led to ensure each s owledge of the emer pecifically describing cking system used to	ot met as evidenced by: d record review, the facility taff demonstrated gency procedures and/or demonstrating the d document locations of					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

		& MEDICAID SERVICES			OMB NO	. 0938-0391
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		E SURVEY
		09G254	B WING_		000	10010040
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 021	08/2019
DC HEA	LTH CARE, INC			WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 037	Continued From pag	je 4	E 03	7		
	Findings included:					
i	facility's tracking systaff during an emerg describe the tracking would take a head co the meeting point at I Tuckerman Street du further stated that shi	AM, DSP #4 said during an ceived training on the tem used to track clients and gency event. When asked to system, DSP #4 stated she to the tem used to the tem		Staff was retrained on 02/12/19 or emergency procedure and the training on the location of both residents staff. QIDP will ensure that staff knowledgeable on the tracking styles weekly discussion and testing 2 weeks and the monthly for 3 m. (Please see Attachment "B1, B2,	acking and is ystem for onths.	02/12/19
	during an emergency At 1:29 PM, interview revealed that she has emergency procedure the locations of clients emergency. When as	conducted with DSP #8 had training on the facility's		DCHC completed a full scale exercise on 02/12/19 with collaboration of all DCHC facilitie in reference to Hurricane Floren DCHC PM/QA will ensure that documentation is available for review in all respective facilities upon completion of drills.		02/12/19
€ # V	count when they evac at Kansas Avenue and to further stated that s vas a form used to do	uated to the meeting point I Tuckerman Street. DSP she was not sure if there scument the location of d they have to evacuate to		(Please see Attachment "C") DCHC is also in communication with DPR/DC to establish contact with recreation centers in DC to develop strategies for upcoming drill.	ot .	
p A m id tir th tra	P last dated 06/14/18 rocedure entitled, "CI coording to the policy naintain daily a attend lentify the whereaboumes during an evacuale policy revealed [agansportation log, staff	track of all the clients and		(Please see Attachment "D") DCHC PM will ensure that full scale/Tabletop drills are complet as per the policy and available for review.	ed	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES	WAY BEGIND OF WHOLE	T	OMB N	IO. 0938-039
AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRU A, BUILDING	UCTION (X3) C	OATE SURVEY OMPLETED
24	09G254	B. WING		1010010515
NAME OF PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STATE, ZIP CODE	2/08/2019
DC HEALTH CARE, INC		WASHINGT	TON, DC 20011	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID P PREFIX : (FAI	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037 Continued From pa	ge 5	E 037		
ensure all staff dem emergency procedu	urvey, the facility failed to constrated knowledge of the cres.			
E 039 EP Testing Requirer CFR(s): 483.475(d)	ments (2)	E 039		
test the emergency	illity, except for LTC facilities, must conduct exercises to plan at least annually. The NHCIs and OPOs] must do			-
the emergency plan a unannounced staff di	at §483.73(d):] (2) Testing. t conduct exercises to test at least annually, including rills using the emergency c facility must do all of the			
exercise is not access facility-based. If the [actual natural or man- requires activation of [facility] is exempt from community-based or if full-scale exercise for	when a community-based sible, an individual, facility] experiences an -made emergency that the emergency plan, the			
(ii) Conduct an addition include, but is not limit (A) A second full-school community-based or in (B) A tabletop exercity discussion led by a fac-	nal exercise that may ted to the following: ale exercise that is adividual, facility-based. ise that includes a group cilitator, using a parrated	*		
clinically-relevant emer	rgency scenario, and a set , directed messages, or		1	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION (X2) MURIPLE CONSTRUCTION A BULLDON B. WING STREET ADDRESS. CITY. STATE, JIP CODE WASHINGTON, DC 20011 STREET ADDRESS. CITY. STATE, JIP CODE WASHINGTON, DC 20011 STREET ADDRESS. CITY. STATE, JIP CODE WASHINGTON, DC 20011 PREFIX REGULATORY OR LISC IDENTIFYING INFORMATION) E 039 Continued From page 6 prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCl's and OPO's] response to and maintain documentation of all tabletop exercises at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to document its efforts used to conduct a full-scale community based exercises with outside sources, for five of five clients residing in the facility (Clients #1, 2, 3, 4 and 5). Findings included:	STATEMENT OF DEFICIENCIES	(VA) BEOVERS OF THE STATE OF TH			OMB NO. 0938-039
DC HEALTH CARE, INC WASHINGTON, DC 20011 FINE PREFIX REGULATORY ON LSC IDENTIFING INFORMATION E 039 Continued From page 6 prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] eeponse to and maintain documentation of all drills, tabletop exercises, and emergency plan, as needed. The RRNHCI's at \$403.748 and OPOs at \$488.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. (iii) Analyze the facility relevant emergency events, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the facility relevant emergency events, and revise the facility relevant emergency exercise at least annually. A tabletop exercise at least annually. A tabletop exercise at old maintain documentation of all tabletop exercise at old maintain documentation of all tabletop exercises and emergency plan. (iii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility falled to document its efforts used to conduct a full-scale community based exercise with outside sources, for five of five clients residing in the facility (Clients #1, 2, 3, 4 and 5). Findings included:	AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY
DC HEALTH CARE, INC CAJ ID SUMMARY STATEMENT OF DERCIENCIES EACH CORRECTIVE ACTION PREFIX REGULATORY ON LSC IDENTIFYING INFORMATION) PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE ACTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) E 039 Continued From page 6 Prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. TFOR RNHCIs at \$403.748 and OPO's at \$486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO's] response to and maintain documentation of all tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility falled to document its efforts used to conduct a full-scale community based exercise with outside sources, for five of five clients residing in the facility (Clients #1, 2, 3, 4 and 5). Findings included:		09G254	B. WING		0204000000000
DC HEALTH CARE, INC (A4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) MUST are PRECEDED BY FULL REGULATORY ON LSC IGENTIFYING INFORMATION) E 039 Continued From page 6 prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the facility's] emergency plan, as needed. '[For RNHCIs at \$403.748 and OPOs at \$486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must conduct exercises is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to document its efforts used to conduct a full-scale community based exercise with outside sources, for five of five clients residing in the facility (Clients #1, 2, 3, 4 and 5). Findings included:	NAME OF PROVIDER OR SUPPLIER			REET ADDRESS, CITY STATE ZIP CODE	02/08/2019
Williams Statement of Deficiencies (EACH Deficiency Must are precision by Full REGULATIONY OR LSC IDENTIFYING INFORMATION) E 039 Continued From page 6 prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.746 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to document its efforts used to conduct a full-scale community based exercise with outside sources, for five of five clients residing in the facility (Clients #1, 2, 3, 4 and 5). Findings included:			1		
prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCls at \$403.748 and OPOs at \$486.360] (d)(2) Testing, The [RNHCl and OPO] must conduct exercises to test the emergency plan. The [RNHCl and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCl's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCl's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to document its efforts used to conduct a full-scale community based exercise with outside sources, for five of five clients residing in the facility (Clients #1, 2, 3, 4 and 5). Findings included:	PREFIX (EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D RE COMPLETION
On 02/08/19 at 1:53 PM, review of the facility's EPP dated November 2017 showed that the facility did not participate in a full-scale community based exercise to present.	prepared questions emergency plan. (iii) Analyze the [facil maintain documental exercises, and emergency] [For RNHCIs at §40 §486.360] (d)(2) Testing must conduct exercises plan. The [RNHCI and following: (i) Conduct a paperleast annually. A table discussion led by a facilinically relevant emergency plan. (ii) Analyze the [RNH to and maintain documexercises, and emergency plan. (iii) Analyze the [RNH to and maintain documexercises, and emergency plan. This STANDARD is in Based on record reviet facility failed to docume conduct a full-scale cowith outside sources, for residing in the facility (Findings included: On 02/08/19 at 1:53 Piepp dated November facility did not participal	designed to challenge an divisition of all drills, tabletop regency events, and revise the y plan, as needed. 3.748 and OPOs at ting. The [RNHCI and OPO] ses to test the emergency and OPO] must do the based, tabletop exercise at atop exercise is a group accilitator, using a narrated, ergency scenario, and a set is, directed messages, or esigned to challenge an accilitation of all tabletop ency events, and revise the emergency plan, as to the met as evidenced by: and staff interview, the ent its efforts used to immunity based exercise for five of five clients Clients #1, 2, 3, 4 and 5). M, review of the facility's 2017 showed that the te in a full-scale.	E 039		

AND PLAN	IT OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY
		BENTH BATTON NOWBER.	A. BUILDING		COMPLETED	
NAME OF	PROVIDER OR SUPPLIER	09G254	B. WING		02/08/2019	
DC HEALTH CARE, INC			1	REET ADDRESS, CITY, STATE, ZIP CODE	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	DRE	(X5) COMPLETIO DATE
	full-scale exercise w about the documents documentation of att full-scale exercise w	iew that he had reached out ources about coordinating a ith the facility. When asked is, the PM stated that he had empts made to coordinate a th outside sources. No	E 039			
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1		X				